| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525528 | A. Building<br>B. Wing | 12/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Franciscan Woods | 19525 W North Ave<br>Brookfield, WI 53045 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | | |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility did not ensure residents at risk for pressure injuries received necessary treatment and services consistent with professional standards of practice to prevent the development of pressure injuries and to promote healing for 1 (R2) of 2 residents reviewed with pressure injuries. R2 was admitted to the facility on [DATE], with a diagnosis of Type 2 Diabetes. There is no documentation the facility was performing daily diabetic foot checks as documented in R2's care plan. R2's care plan does not document person centered interventions of turning and repositioning when R2 is assessed to be dependent on the staff for activities of daily living (ADLs). On 11/1/25, R2's family notified the facility of R2 having bilateral heel pressure injuries. The facility documented the size and location of a left heel pressure injury but did not complete an assessment of R2's right heel prior to R2's transfer to the hospital. R2 was sent to the emergency room (ER) for evaluation and the hospital documents bilateral heels with pressure ulcer with black scabs. R2 returned to the facility on [DATE]. R2's skin was not comprehensively assessed until 11/9/25, ordered treatments were not implemented until 4 days after they were ordered.Findings include:The facility's policy titled, Pressure Injury Assessment/Treatment and dated 12/2016, last reviewed 7/2024, documents:General Guidelines:The pressure injury treatment program should focus on the following strategies:*Evaluating the resident and the current status of the pressure injury. *Observe currently used support surfaces and/or pressure relieving devices; initiate as needed.*Resolution of current pressure injuries and prevention of additional pressure injuries.*Identification of additional nutritional needs to aide in wound healing.*Education and quality improvement.Pressure injury treatment requires a comprehensive approach, including and not limited to:*Elimination or reduce the source of pressure using positioning techniques.*Preventative measures to reduce the risk of further tissue loss. *Managing and reducing the risk of infections.*Interventions that increase the potential for healing.*Managing systemic issues. The facility's policy titled Nursing Care of the Resident with Diabetes Mellitus and dated 12/2016, last reviewed 11/2024, documents:Complications Associated with Diabetes:Foot complications - neuropathy, dry skin, calluses, poor circulation, and ulcers.Skin and Foot Care:Skin should be kept as dry and clean as possible.Apply lotion to dry skin as needed, unless contraindicated.Use aseptic technique in caring for any lacerations, abrasions or breaks in skin integrity, and report the condition immediately to your supervisor.Bathe feet in warm (not hot) water as necessary to keep clean.Keep feet dry, especially between toes.Encourage the use of non-constricting, well-fitting shoes, slippers and hose.Keep feet warm without the use of external heat sources.Toenails should only be trimmed by associates qualified to do so. Documentation:Assessment of the skin including color, moisture, temperature, any redness, ulcers, irritation, abrasions, and/or pruritus (itching).Assessment of the feet should include the following:Hygiene, temperature, color, circulation, any abrasions, sores and/or injuries. R2 was admitted to the facility on [DATE]. R2's diagnoses include cerebral infarct (part of the brain tissue dies), heart failure (weakened heart or stiff heart pumping), chronic kidney disease (CKD) (damaged kidneys), Diabetes (high blood sugar levels in the body), Chronic Obstructive Pulmonary Disease (COPD) (lung condition caused by damage to the lungs), Atrial Fibrillation (irregular heart beat), Peripheral Vascular Disease (PVD) (narrowed blood vessels to the legs causing reduced blood flow), dementia (memory concerns due to damaged brain cells), hemiplegia (weakness) affecting left side, and muscle weakness.Surveyor notes R2 discharged from the facility on 11/21/25. R2's admission Minimum Data Set (MDS) completed on 9/12/25, documents R2 is dependent with toileting, showering, dressing, and transfers. R2 was assessed as being at risk for pressure injuries with no unhealed pressure injuries. R2's Care Area Assessment (CAA) for pressure injuries documents, proceed to plan of care. Surveyor notes no further documentation in R2's pressure injury CAA.R2 was documented as having a Brief Interview for Mental Status (BIMS) score of 13, indicating R2 is cognitively intact.R2's readmission MDS completed on 11/11/25, documents R2 is at risk for pressure injuries with no unhealed pressure injuries, venous or arterial ulcers. R2's MDS documents R2 as having Diabetic foot ulcers.R2's Discharge MDS completed on 11/18/25, documents R2 having 2 unhealed unstageable pressure injuries with slough and/or eschar. Surveyor reviewed R2's Electronic Medical Record (EMR) which documents the following Braden Scales (a tool that assesses a resident's risk of developing pressure injuries):Braden Scale scoring:Score 15 - 18 indicates low risk with interventions to reposition regularly, keep positioned off bony prominences.Score 13 - 14 indicates moderate risk with interventions to initiate turning schedule every 2 |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, interview and record review the facility did not ensure the medication error rate was below 5% during medication pass. Surveyor observed 20 out of 32 opportunities with a medication error rate of 62.5%. On 12/18/25, Surveyor observed Licensed Practical Nurse (LPN)- E stab 20 bubble packs with a pen for 2 (R8 and R9) of 4 residents during medication administration. Findings include: On 12/18/25, at 7:54 AM, Surveyor observed LPN-E administer medications to R9. R9 was administered 8 medication that included:Amlodipine 5 mg tabletCertravite (Multivitamin) 1 tabletFolic Acid 1 mg tabletHydrochlorothiazide 12. 5 mg tabletTurmeric 500 mg tabletVitamin B complex 1 tabletThiamine 100 mg tabletVitamin C 500 mg tabletSurveyor observed each medication to be individually wrapped in a bubble packet and observed LPN-E lay out all 8 bubble packs on top of the medication cart and press the button on her pen to expose the ballpoint on the pen and stab each individual packet with the open ball point pen. LPN-E then placed each bubble pack over a medicine cup to push out the tablet into the medication cup. LPN-E then walked over to R9 who swallowed the medications whole with water. On 12/18/25, at 8:29 AM, Surveyor observed LPN-E administer medications to R8. R8 was administered 12 medications that included:Tamsulosin 0.4 mg (2 tablets)Losartan 50 mg tabletMemantine 5 mg tabletMetoprolol Extended Release (ER) 25 mg tabletThiamine 100 mg tabletVitamin K with D3 100 mcg tabletAspirin 81 mg tabletChlorthalidone 25 mg tabletCoQ10 100 mg tabletFolic Acid 1 mg tabletGabapentin 300 mg tabletGlimepiride 2 mg tabletSurveyor observed each medication to be individually wrapped in a bubble packet and observed LPN-E lay out all 12 bubble packs on top of the medication cart and press the button on her pen to expose the ballpoint on the pen and stab each individual packet with the open ball point pen. R8 overheard LPN-E stabbing the bubble packs from the hallway and yelled out to LPN-E, stating R8 did not want their medications crushed. LPN-E responded to R8 stating she did not have fake nails to open the bubble packs and was not crushing R8's medications. LPN-E then placed each bubble pack over a medicine cup to push out the tablet into the medication cup. LPN-E then walked over to R8 who swallowed the medications whole with water. On 12/18/25, at 10:54 AM, Surveyor notified Director of Nursing (DON)-B of concerns with performing observations of medication pass with 32 opportunities. Surveyor notified DON-B of Surveyor observing LPN-E stabbing 20 bubble packs open with a ball point pen exposed to break medication bubble packs which makes a 62.5% medication error rate with 20 out of 32 opportunities. DON-B acknowledged the concerns. |